DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-019

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-06

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA)

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ -0-
b. FFY 02 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Section 2, Page 2, 2a, 2b, 2c, * 2d, 2e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Section 2, Page 2

10. SUBJECT OF AMENDMENT:
Rural Health Clinics and Federally Qualified Health Clinics

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Carmen Hooker Buell

13. TYPED NAME:
Carmen Hooker Buell

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 30, 2001

16. RETURN TO:
Office of the Secretary
Department of Health & Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 30, 2001

18. DATE APPROVED:
October 24, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
*** State Agency authorized "pen and ink" change to add to column 8 new pages, 2d and 2e.**

FORM HCFA-179 (07-92)

Instructions on Back

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.b. Rural health clinic (RHC) services and other ambulatory services furnished by a rural health clinic. Subparagraph (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

(1) Effective for dates of service occurring January 1, 2001 and after, RHCs are reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the RHC (calculating the payment amount on a per visit basis).

(A) In determining the initial PPS rate, cost caps for core services shall continue to be used to determine reasonable cost, as established by Medicare.

(B) The clinic's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an RHC patient and any health professional whose services are reimbursed under the State Plan.

(D) In the case of any RHC with a managed care organization, supplemental payments will be made no less frequently than every four months to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(2) At the beginning of each clinic's fiscal year, subsequent to January 1, 2001, the rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Medical Assistance shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) Newly qualified RHCs after December 31, 2000, will have their initial rates established either by reference to rates paid to other clinics in the same or adjacent areas with similar caseload, or in the absence of such other clinics, through cost reporting methods. Rates for subsequent fiscal years shall be based on the same update methods reflected in subparagraph (2) above.

(4) Notwithstanding the above, interim fiscal year 2001 rates shall be the rates currently in effect on December 31, 2000, since information needed to establish rates per subparagraph (1) is not currently available.

(A) These rates shall be adjusted annually in accordance with subparagraph (2) of this paragraph.

(B) These rates shall be adjusted based on available as filed cost reports, in accordance with subparagraph (1) of this paragraph.

(C) These rates shall be settled and reconciled back to January 1, 2001 in order to establish the permanent prospective rates determined in accordance with subparagraph (1) once audited cost reports become available.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(5) Providers may elect to continue to be reimbursed in accordance to the methodology in effect on December 31, 2000, covering rural health clinic services and other ambulatory services furnished by a rural health clinic.

(A) The initial election must be done within ninety days of the approval of this state plan amendment.

(B) Providers may change the initial election one time prior to January 1, 2005. Said change must be made no later than ninety days after the start of the applicable fiscal year.

(C) Rates paid under this methodology must be at least equal to the payment under the payment methodology included in subparagraph (1) and (2).

(D) Provider clinics are paid on the basis of the principles and at the Medicare determined rates specified in the Medicare regulation in Part 405, Subpart D not to exceed the Medicare established limits.

(E) Independent clinics are paid for all services offered by the clinic at a single cost-reimbursement rate for clinic visit, established by the Medicare carrier, that includes the cost of all services furnished by the clinic.

(F) Effective October 1, 1993, physician-provided services at a hospital inpatient or outpatient location are paid at the existing fee-for-service rate for those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the rural health clinic location.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.c. Federally qualified health center (FQHC) services and other ambulatory services furnished by a federally qualified health center. Subparagraph (1) through (5) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

(1) Effective for dates of service occurring January 1, 2001 and after, FQHCs are reimbursed on a prospective payment rate. The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the center's fiscal years 1999 and 2000, adjusted to take into account any increase (or decrease) in the scope of services furnished during fiscal year 2001 by the FQHC (calculating the payment amount on a per visit basis).

(A) In determining the initial PPS rate, cost caps for core services shall continue to be used to determine reasonable cost, as established by Medicare.

(B) The center's average fiscal years 1999 and 2000 cost shall be calculated by adding the total reasonable costs together for fiscal year 1999 and fiscal year 2000 and dividing by the number of visits.

(C) A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan.

(D) In the case of any FQHC with a managed care organization, supplemental payments will be made no less frequently than every four months to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(2) At the beginning of each center's fiscal year, subsequent to January 1, 2001, the rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Medical Assistance shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) Newly qualified FQHCs after December 31, 2000, will have their initial rates established either by reference to rates paid to other centers in the same or adjacent areas with similar caseload, or in the absence of such other centers, through cost reporting methods. Rates for subsequent fiscal years shall be based on the same update methods reflected in subparagraph (2) above.

(4) Notwithstanding the above, interim fiscal year 2001 rates shall be the rates currently in effect on December 31, 2000, since information needed to establish rates per subparagraph (1) is not currently available.

(A) These rates shall be adjusted annually in accordance with subparagraph (2) of this paragraph.

(B) These rates shall be adjusted based on available as filed cost reports, in accordance with subparagraph (1) of this paragraph.

(C) These rates shall be settled and reconciled back to January 1, 2001 in order to establish the permanent prospective rates determined in accordance with subparagraph (1) once audited cost reports become available.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(5) Providers may elect to continue to be reimbursed in accordance to the methodology in effect on December 31, 2000.

(A) The initial election must be done within ninety days of the approval of this state plan amendment.

(B) Providers may change the initial election one time prior to January 1, 2005. Said change must be made no later than ninety days after the start of the applicable fiscal year.

(C) Rates paid under this methodology must be at least equal to the payment under the payment methodology included in subparagraph (1) and (2).

(D) Services furnished by a federally qualified health center (FQHC) are reimbursed at one hundred percent (100%) of reasonable cost, not to exceed the Medicare established limits, as determined in an annual cost report, based on Medicare principles and methods when:

(1) It is receiving a grant under Section 329 (migrant health centers), 330 (community health centers) or 340 (health care centers for the homeless), Public Housing Health Centers receiving grant funds under Section 340A of the Public Health Service Act and Urban Indian organizations receiving funds under Title V of the Indian Health Improvement Act are FQHC's effective calendar quarter beginning or after October 1, 1993;

(2) It meets the requirements for receiving a Public Health Service grant or was treated as a comprehensive federally funded health center as of January 1, 1990

(3) Nutrition services are provided by rural health centers and FQHC. Providers are reimbursed in accordance with reimbursement methodologies established for services provided by rural health clinics and FQHCs as based on Medicare principles.

(4) Effective October 1, 1993, physician-provided services at a hospital inpatient and outpatient location are paid at the existing fee-for-service rate for those clinics whose agreement with their physician states that the clinic doesn't compensate the physician for services in a location other than at the federally qualified health clinic location.

NORTH CAROLINA
STATE PLAN AMENDMENT REVIEW SHEET

TRANSMITTAL # 01-24 DATE ASSIGNED 10/26/01

STATE COORDINATOR: DONNA CROSS

****

	TYPE OF TRANSMITTAL	**ACTION DATES**	
X	New Plan Amendment	Date Rec'd in HCFA	10/25/01
___	Comments From CO	15-Day Status	See Below
___	Response from State	60th Day Alert	12/24/01
___	Withdrawal/SPA Response	90th Day	01/23/02
___	Withdrawal/Plan Amendment		
___	Revised/Substitute Page(s)		
___	Other _____		

REVIEWER'S RECOMMENDATION

___	Draft Letter to CO	Approval	___
___	Official Letter to SA	Partial Approval	___
___	Partial Disapproval	Recommending Disapproval	___

COMMENTS AND/OR INSTRUCTIONS

15-Day Status: _____

_____

_____

_____

_____

_____ _____

REVIEWER SIGNATURE **DATE**

****

SUPERVISOR'S CONCURRENCE

_____ _____

SUPERVISOR SIGNATURE **DATE**

****

COMPLETED BY STATE PLAN COORDINATOR: **DATE:** _____

North Carolina Department of Health and Human Services
2001 Mail Service Center •Raleigh, North Carolina 27699-2001
Tel 919-733-4534 •Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Buell, Secretary

October 17, 2001

Mr. Eugene A. Grasser
Associate Regional Administrator
Division of Medicaid
Centers for Medicare and Medicaid Services
Region IV
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2001-24

Dear Mr. Grasser:

Please find enclosed an amendment to North Carolina's State Plan for Medical Assistance. This change affects Text pages 9c, 9d, 9e, 9f, and 9g.

This amendment allows the Division of Medical Assistance the opportunity to offer two different health care options to Medicaid recipients. The current managed care organization will be terminating their contract no later than September 30, 2001.

This amendment is submitted for an effective date of October 1, 2001.

Your approval of this amendment is requested.

Sincerely

Carmen Hooker Buell

Carmen Hooker Buell

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **01 – 24**

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2001**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1932 (a) (1) (A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 01-02 $ (4,932,230.60)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Text pages 9c, 9d, 9e, 9f and 9g

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Text pages 9c, 9d, 9e, 9f, and 9g

10. SUBJECT OF AMENDMENT:
Mandatory Managed Care Enrollment

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Carmen Hooker Buell

13. TYPED NAME:
Carmen Hooker Buell

14. TITLE:
Secretary

15. DATE SUBMITTED:
October 17, 2001

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carlina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

I. Assurances

A. The State assures that all requirements of sections 1903(m), 1932 and 1905(t) will be met for its mandatory managed care programs, which include Carolina ACCESS, ACCESS II, and Health Care Connection. A brief description of each program follows:

- Carolina ACCESS, implemented in 1991, is the State's primary care case management program in which the primary care provider (PCP) coordinates patient care and acts as a gatekeeper. Providers are reimbursed fee for service and the PCPs receive a management fee for each recipient.
- Access II, launched in July of 1998, is an enhanced primary care case management program in which Carolina ACCESS PCPs have joined together to form distinct networks headed by an administrative entity. The networks have developed care management and disease management strategies targeted to their respective populations. The PCPs receive the standard management fee and all providers are paid on a fee-for-service basis. The administrative entity receives an additional management fee for the enhanced services.
- Health Care Connection, which began operating in June of 1996, is the State's mandatory HMO program in Mecklenburg County. Recipients must enroll in one of several participating HMOs or with a Federally Qualified Health Center.

Carolina ACCESS is the largest of the three programs and is viewed as the cornerstone of Medicaid managed care. ACCESS II is an enhancement of the Carolina ACCESS PCCM model. As of October 1, 2001, ACCESS II will be operational in Mecklenburg county.

In addition to these programs, the State contracts with HMOs in Mecklenburg county, giving recipients an opportunity to choose between ACCESS II and an HMO.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

B. The State assures that the following populations will be exempted from mandatory enrollment in Carolina ACCESS, Access II, and Health Care Connection under the State Plan option:
(1) Dual Medicare-Medicaid eligibles;
(2) Indians who are members of Federally-recognized tribes; and,
(3) All children under 19 years of age.

With the exception of the populations listed in I.B, recipients in the following aid categories will be required to enroll in one of the managed care programs described above:*

- Work First for Family Assistance (formerly AFDC)
- Family and Children's Medicaid without Medicaid deductibles (formerly AFDC-related)
- Medicaid for Pregnant Women (MPW)**
- Medicaid for the Bind and Disabled (MAB, MAD, MSB)
- Residents of Adult Care Homes (SAD)

Children under the age of 19 in any of the covered categories are exempt under mandatory enrollment.

*Individuals who are residing in a nursing facility or in an intermediate care facility for the mentally retarded and individuals who have an eligibility period that is only retroactive are not eligible for enrollment in managed care.

**Enrollment is mandatory for MPW recipients who are eligible for Health Care Connection; enrollment is optional for MPW recipients who are eligible for Carolina ACCESS and/or Access II.

C. The State assures that all individuals will have a choice of at least two managed care entities. Carolina ACCESS is operating in all of the State's 100 counties, and Access II exists in several of these counties as well. All individuals covered under this option who reside in these counties will be able to choose from among multiple Carolina ACCESS primary care case

managers. Individuals residing in counties with both Carolina ACCESS and Access II will be able to choose between both programs and from among multiple primary care case managers.

Health Care Connection allows voluntary enrollment in an HMO for Medicaid recipients in Mecklenburg County. Recipients in this county have a choice of participation in one of several HMOs, ACCESS II or a FQHC.

D. The State assures that beneficiaries will be permitted to disenroll from a managed care plan or change Carolina ACCESS/ACCESS II PCPs without cause in the first 90 days of enrollment and at least every twelve months thereafter. Recipients will be able to disenroll at any time with cause.

E. The State assures that default enrollment will be based first upon maintaining existing provider-patient relationships. Most beneficiaries receive education as to their managed care options verbally through staff at their respective county department of social services. Inquiries are made for potential default enrollment as to current provider-patient relationships when recipients do not select a primary care provider or HMO at the time of the visit. Some beneficiaries, particularly SSI recipients, do not visit the social services office for Medicaid application and/or reapplication. In these cases, written materials describing the managed care options are mailed to them along with a deadline for notification of PCP/HMO selection. Attempts are made to contact beneficiaries by telephone or letter if they do not respond within the time frame; inquiries are made about existing relationships with providers when contact is made.

If it is not possible to obtain provider-patient history, beneficiaries are assigned to providers based upon equitable distribution among participating managed care entities, including PCPs and HMOs as available in the recipient's county of residence.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

F. The State assures that it will provide information to beneficiaries in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, and benefits not covered by the managed care plan. The State provides comparative information on benefits and cost sharing, service areas, and the special features of each MCE. The State assures HCFA that it will also provide comparative information on quality and performance of participating managed care entities to the extent that this information is available. All information will be written in language at the fifth grade level of reading comprehension.

II. Efforts are made to recruit all qualified providers as Carolina ACCESS PCPs, and as a result, the program has increased access to care for Medicaid recipients in North Carolina. Each PCCM provider may serve a maximum of 2000 recipients. Prior to enrollment participants are given a list of providers serving their respective counties from which they select a PCP; they are able to continue using providers in neighboring counties who are enrolled as Carolina ACCESS PCPs. All PCPs must provide 24-hour call coverage, seven days a week. In addition, a number of county social services agencies have a managed care representative on-site, whom beneficiaries may contact for assistance if there is an access problem. The State also operates a toll-free managed care hotline for Medicaid recipients and providers. Recipient surveys, which address access, wait times, delays in getting appointments and other issues related to quality, are completed periodically. Access problems that are detected as a result of recipient surveys are addressed in a number of ways, depending on the nature and urgency of the problem. Generally, contact is made with the provider to evaluate the issue; depending on the outcome of the evaluation, a corrective action plan might be implemented and/or the provider might be sanctioned. An example of a sanction would be suspension of management fees or restricting the provider from taking on additional Carolina ACCESS patients.

HMOs participating in Health Care Connection were selected for participation only after careful review of the provider networks in terms of capacity, geographical

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

location and types of specialties available to the Medicaid population. Participating HMOs have specific appointment availability and wait time requirements for Medicaid enrollees as well as a nurse advice line that operates 24 hours a day. A contracted health benefits advisor has placed telephones, referred to as "blue" phones, that provide a direct connection to the health benefits advisor staff in the Mecklenburg County Department of Social Services. A toll-fee hotline is also available to beneficiaries if they have a problem with access. As part of the internal managed care quality assurance program, each HMO is required to complete satisfaction surveys annually and share the results with the State Medicaid Agency. In addition, the State periodically surveys a sample of Health Care Connection participants to determine their satisfaction with care, including such items as appointment availability, wait times, and overall satisfaction with care through the HMO.

III. The State contracts with PCCM providers through the Carolina ACCESS and Access programs and assures that the contracts contain all terms under section 1905(t)(3) of the Act. PCCM providers in Carolina ACCESS and Access II are reimbursed on a fee-for-service basis and receive a management fee as well. The types of providers who can contract with the Division of Medical Assistance to participate as primary care providers in the PCCM programs are:

General Practitioners	Nurse Practitioners	Family Physicians
Hospital Outpatient Clinics	Pediatricians	Internists
Obstetricians	Health Departments	Gynecologists
Rural Health Clinics	Physician Assistants	Community Health Centers
Federally Qualified Health Centers		

In certain situations where deemed necessary, a specialist may be allowed to participate as a PCCM provider. For example, a patient who is on dialysis might be receiving primary care from a nephrologist, or; a patient who is receiving long-term treatment for cancer might need to have his or her care coordinated by an oncologist. These are often linkages that are established prior to implementation of the PCCM program within a county; the State attempts to maintain these linkages if it is in the best interest of the patient's medical care.